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ABSTRACT

The current mental health systen suffers frcm fragmentation and inefficient utilizatien cf all pctential mental health resources, and paraprofessionals can be utilized as bridging agents between formal agencies and nonprcfessicnal community caregivers. Arguments for conceptual reorganization of the mental health delivery system are presented, beginning with a brief historical overview of the development of current ccmmunity-based approaches. Major issues and concerns invclved in developing nonprofessional, paraprofessional and professional resources are delineated. The purposes and functions of various types of nonprofessional caregivers are described; their current relaticnship to formal mental health systems is presented; the role of paraprofessionals as bridging agents is discussed; and principles and recommendations for linking mental health agencies, paraprofessionals and nonprofessional community caregivers are suggested. (Author)

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PARAPROFESSIONALS AS A BRIDGE BETWEEN AGENCIES AND NONPROFESSIONAL COMMUNITY CAREGIVERS

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The purpose of this paper is to examine the role of the nonprofessional community caregiver in relation to the overall system of mental health services. Particular emphasis will be given to the relationship between the paraprofessional and the nonprofessional caregiver on the one hand and established mental health agencies on the other hand. Specifically, we will focus on four issues:

1. The utilization of nonprofessional community caregivers as an outgrowth of emerging developments in the field of mental health.
2. The purposes and functions of various types of nonprofessional caregivers and their current relationship to formal mental health systems.
3. The changing role of paraprofessionals as bridging agents and their potential role as a link between nonprofessional caregivers and formal mental health agencies.
4. Principles and recommendations for developing an integrated, comprehensive mental health system through the utilization of nonprofessional, paraprofessional and professional resources.

The basic theme of this paper is that our current mental health system suffers from fragmentation and inefficient utilization of all potential mental health resources. This condition has been created by conceptual and behavioral narrowness and rigidity brought on by a variety of forces, including inadequate understanding and a lack of role clarity. The resolution of this

problem requires conceptual reorganization and intensive efforts to establish open channels of communication among the principal parties involved in the mental health delivery system.

THE IMPACT OF EMERGING DEVELOPMENTS IN MENTAL HEALTH ON THE UTILIZATION OF NONPROFESSIONAL COMMUNITY CAREGIVERS

Several developments during the past few years have intensified our focus on the potential contribution of a nonprofessional caregiver. While the length of this paper does not allow for an elaborate discussion of these developments, a brief mention of the major sources of influence may provide a prespective for viewing the potential role of nonprofessional caregivers. Changes in the manner in which mental health services are conceptualized and delivered have led to a reassessment of who delivers services, as well as how and where they are delivered. The thrust toward deinstitutionalization, the emphasis on normalizing living patterns for the mentally disabled, the notion of providing support services as a vehicle for maintaining community functioning and the stress on enabling individuals to develop and maintain competencies through skill building and increased accessibility to physical and nonphysical supplies and resources have brought to our attention the need for developing new roles for mental health personnel and identifying new sources of community-based person power.

General societal forces and conditions have also had an impact on our prespective. On top of the general spiral of inflation and recession that we have experienced, we must now confront the increasing reluctance

of citizens to dole out their limited financial resources for public services. This theme, most recently exemplified by the tax revolt in California, represents a major factor in the trend toward fiscal and social conservatism. We are now at a critical pivotal juncture. With the demonstrated correlation between general social climate and the prevalent mental health ideology, so well articulated by Murray Levine and others, it is clear that we are in real danger of moving backward in our quest to humanize the way in which mentally disabled are treated. On the other hand, we have not really tested a notion that with carefully reasoned plans and practically oriented strategies we can develop approaches that will retain the positive thrust of our community oriented approaches, while contributing to the growing concern for government efficiency. In other words, it may be possible to demonstrate that through a careful use of natural resources--both environmental and human--it is possible to provide quality care for mentally disabled individuals in an efficient and cost effective manner. Rather than letting the flow of mental health services be diverted by the strong current of public dissatisfaction and frustration, we may be able to find a channel that not only allows us to continue our progress, but also provide us with additional momentum. This will not be an easy task. It will require not only the development of effective concepts and programs, but also a massive effort to educate the public. We must increase the community's level of tolerance and acceptance of disabled individuals, as well as work toward a redefinition of community responsibility for its citizens.

This line of reasoning logically leads us to the idea that we must make greater use of resources that exist in the natural environment. We have already seen how the utilization of paraprofessionals can contribute to the efficiency and effectiveness of community mental health services. Now we must take this reasoning one step further. In addition to the use of paraprofessionals, we must explore ways in which we can use the wide range of other nonprofessional community caregivers. This would include volunteers, peer counselors, self-help--or as Marie Killilea prefers to call them, mutual help groups--, and natural helpers and support systems.

NONPROFESSIONAL COMMUNITY CAREGIVERS

There are several reasons why the use of nonprofessional caregivers is compatible with current conceptions of mental health. First, nonprofessional caregivers often provide their services in the natural environment rather than in formal institutions. Second, these programs involve service providers who may closely resemble service consumers in cultural and personal characteristics. In addition, nonprofessionals are often consumers, as in the case of mutual help groups. In keeping with the philosophy that consumers should be involved in the delivery of mental health services, nonprofessional programs provide considerable opportunity for consumer responsibility in the areas of service implementation and social change. Finally, nonprofessional caregivers represent a rich source of personnel for providing support to those who are trying to live and to function in community settings. The reports of research by Caplan, Cassel, Cobb, Myers and others have demonstrated clearly that social support and

integration are significant forces in the prevention and reduction of mental disability as well as necessary component in the maintenance of psychological well-being in community functions. Caplan describes eloquently the positive role of support systems, which he defines as "continuing social aggregates (namely, continuing interactions with another individual, a network, a group or an organization) that provide individuals with opportunity for feedback about themselves and for validation of their expectations about others, which may offset deficiencies in these communications within the larger community context." (Caplan, 1974).

The recent report of the President's Commission on Mental Health also underscored the importance of utilizing natural resources and support systems, such as mutual help groups. If one considers the repeated research finding that persons with mental health problems do not typically turn to mental health professionals, but instead utilize doctors, clergy, family, friends, and other members of the natural community network, it becomes apparent that nonprofessional caregivers are a valuable source of community support assistance for persons experiencing crises and mental disabilities. It has already been demonstrated through controlled research that paraprofessionals are able to effectively provide mental health services (Brown, 1974; Cohen, 1976; Durlak, 1973; Gartner, 1971 and 1977; Karlsruher, 1974). While it is more difficult to conduct well-designed research with nonprofessional caregivers, many of whom function in natural environments not conducive to controlled investigation, there is some evidence that nonprofessionals can effectively provide personal and social support. Summarizing his review of studies related to social support as a moderator of life's stress, Cobb (1976) observes: "the conclusion that supportive interactions among people are

important is hardly new. What is new is the assemblying of hard evidence that adequate social support can protect people in crisis from a variety of pathological states: from low birth weight to death, from arthritis through tuberculosis to depression, alcoholism and other psychiatric illness."

Katz and Bender (1976) identified four basic types of self-help groups: 1) those which are concerned with the self-fulfillment of personal growth of their members; 2) those that emphasize social advocacy, both for purposes of changing institutions and influencing public policies, and to improve opportunities for specific individuals and groups; 3) those whose primary purpose is to establish alternative living and working patterns; and, 4) those whose basic purpose is to provide a refuge for desperate individuals who seek asylum from the problems and pressures of the mainstream. They conclude from their review of self-help groups that many member-participants have clearly benefited from their association with these groups.

A number of studies have shown that volunteers can be effective therapeutic and change agents. These studies have focused on a diverse range of volunteer groups, including volunteer mothers (Cowen, 1968; Magoon, Golan and Freeman, 1969), retired persons (Cowen, Leibowitz, and Leibowitz, 1968; Johnston, 1967), parents (Stover and Guerney, 1967), and former psychiatric clients (Fairweather, Sanders, Cressler, Maynard, 1969). In general, there appears to be growing body of research supporting the efficacy of utilizing nonprofessional mental health caregivers. While we have not yet gathered definitive empirical data on all of the important questions, the value of nonprofessionals has been established.

CURRENT RELATIONSHIP BETWEEN NONPROFESSIONAL CAREGIVERS AND THE MENTAL HEALTH ESTABLISHMENT

Unfortunately, the relationship between the formal mental health

agencies, composed primarily of professionals, and the various nonprofessional caregiving groups is generally less than harmonious. With few exceptions, the development of good working relationships between nonprofessional and professional caregiving groups has been hampered by problems of conflict of style and philosophy, with the issue of mutual-help groups maintaining their autonomy and sense of identity being an especially difficult obstacle to overcome. (Kleiman, Mantell and Alexander, 1976)

The current dilemma is graphically illustrated by the results of a recent survey by Leon Levy (1978). He found, in response to a questionnaire distributed to 1,800 mental health agencies throughout the country, that professionals were increasingly recognizing the value of self-help groups, but were concerned about the problems of developing and implementing relationships between their agencies and self-help groups. The discrepancy between attitude and action is illustrated by his finding that 85% of the professionals recognized the effectiveness of self-help, but only 30% believed their agencies would be interested in exploring collaborative relationships with self-help groups. The lag between attitude and practice is large enough to warrant serious attention to the issue of how we can bridge the gap between these two critical components of the mental health system.

PARAPROFESSIONALS AS BRIDGING AGENTS

The original conception of paraprofessionals put forth by Pearl and Riessman (1965), emphasized the ability of the paraprofessional to serve as a bridge between the agency and the community. It was postulated that because paraprofessionals shared a common background in values with the community, and came to their work with an activist orientation, they would be able to assist in interpreting the needs of a client to the agency, and the value of the

agency's services to the members of the community. Since that time, the bridging function has come under careful scrutiny and a number of questions have been raised about the legitimacy of this notion. Arguments against the viability of the paraprofessional bridging role include:

1. Today's paraprofessionals, in fact, do not share the same background as some of the consumers they were originally intended to serve. With increasing competition for jobs in a tight economy, many paraprofessional positions have been filled by more highly educated persons coming from middle and upper-middle socio-economic classes. (Berman and Haug, 1973). These paraprofessionals do not identify as much with working people, blacks and poor people as change agents.
2. Riley, Wagonfeld and Rubin ( ) found that today's paraprofessionals are generally not any more oriented toward activism than professionals. They raise the question of whether paraprofessionals are being selected by a process of "creaming," resulting in a more highly educated group of workers.
3. In a study of work functions of paraprofessionals, Lifton, Nash and Benjamin (In Press) found that only 1% of a group of human service workers trained in a paraprofessional program were involved in community functions, such as community relations and consultation.
4. Berman and Haug (1973) found in their study of paraprofessional students that less than 10% of them saw their role as clarification for both client and agency.

On the surface, these findings might be interpreted as indicating a failure of the paraprofessional bridging concept. However, an alternative perception would be that refinement and modification of stereotyped ideas and current staff deployment practices is in order. For example, Pattison (1978) notes the danger inherent in developing a split between the roles of professionals and paraprofessionals. To assume that paraprofessionals are the only ones who relate to the community and professionals somehow should limit their domain to agency-based work, creates a work situation which fosters conflict and confusion, as well as impedes the development of a comprehensive service system. Pattison asks us to reconsider the roles of paraprofessionals and professionals. He proposes the notion of "skilled role differentiation," in which everyone possesses some general skills, but also varying levels of increasing skill and knowledge for more complex tasks. Under the system of skilled role differentiation persons would be identified to serve as liaisons among agencies, consumers, and nonprofessional caregiving groups on the basis of personal qualities and skills rather than by virtue of some abstract social classification. The concept of the Human Service Generalist, being developed by NIMH, also provides for the utilization of paraprofessional case managers who would be trained to link clients with relevant groups and agencies in various human service fields.

In their study of students involved in paraprofessional training, Berman and Haug (1973) raised the question of whether an orientation of upward mobility--concern with a career ladder--was incompatible with a focus on delivering services to people--a bridging function. Although

they do not answer this question definitively, they suggest - and I would concur - that concern with personal advancement and interest in meeting the needs of others can co-exist compatibly.

We must recognize that our current era is not characterized by the strong social action orientation that existed in the 1960s. There is more focus on individual service and the provision of individual rights, as opposed to total social reconstruction. In the absence of an intense climate of social activism, it is tempting to retreat from a position of community involvement into a shell of conservatism and despair. A more constructive alternative would be to redefine staffing and program patterns. The new design should make optimal use of community resources in a comprehensive integrated mental health service system, directed at providing high quality individual service and care in community-based settings. To accomplish this task it will be necessary to develop viable ways in which both paraprofessionals and professionals can relate to the vast array of nonprofessional caregivers. Certainly paraprofessionals need to play a major role in this effort, but, unlike earlier approaches, we need to realize the importance of involving professionals also.

PRINCIPLES OF UTILIZING NONPROFESSIONAL CAREGIVING RESOURCES

If we are to move toward the development of a truly comprehensive mental health service system, it will be necessary to restructure some of our thinking. The system should not be viewed as a unitary system; rather it might be conceptualized as an extended continuum of resources which complement each other, and at times, interact with each other. The linkages between the formal and informal components of the system must be maintained,

but not at the expense of sacrificing the unique characteristics and qualities of the various components. In order to move toward a greater state of harmony, we will need to break down some of the existing stereotyped notions about the various individuals and groups involved in mental health service delivery. Included among the stereotypes that need to be broken down are the following:

a) All paraprofessionals are the same. In addition to varying levels of competence, it should be apparent by now that some paraprofessionals are highly qualified to perform bridging functions, while others are not. Of course, the corollary of this stereotype is that all professionals and all other nonprofessionals are all the same.

b) Professionals and self-help groups are mutually exclusive and incompatible. Here we need to become aware of the fact that professionals have played an instrumental role in the development and maintenance of many mutual-help and community support systems. (Katz and Bender, 1976)

c) Mental health services should be delivered under a single auspice and setting. It is possible, and even desirable, to utilize variety of agencies and groups for different aspects of functioning, such as shelter, work, and social functioning. The critical element here is that these various services and functions be linked to provide continuity and coordination. However, these services and settings may be

administered by a variety of professional, paraprofessional and other nonprofessional caregiving groups and agencies.

With a balanced perspective of the mental health delivery system and the large number of urgent problems it needs to address, it becomes apparent that we need to improve the intercoordination of the various components of this system. Toward this end, one legitimate role for certain paraprofessionals--and certain professionals--is the identification, mobilization and utilization of the multitude of resources in the natural environment, and facilitation of linkages between mental health consumers and these resources. The question that remains is how can we enhance the relationships among mental health agencies, nonprofessional caregiving groups and consumers?

POLICY RECOMMENDATIONS TO ENHANCE THE UTILIZATION OF NONPROFESSIONAL CAREGIVING RESOURCES

Efforts to strengthen these linkages must be directed at all levels--local, state and national. Some of the directions in which policy and program refinement and development are required include:

a) The establishment of support for research to develop effective models for professionals, paraprofessionals, and nonprofessional caregivers to work together in a comprehensive system without compromising the integrity or autonomy of any group.

b) The development of training programs to prepare paraprofessionals to be case managers and bridging agents to community nonprofessionals and support systems.

c) The establishment of training programs to prepare professionals to work more effectively with community nonprofessionals and support systems.

d) The initiation of local, statewide and national efforts to develop a systematic plan for identifying the types of tasks that can be performed by various nonprofessional caregivers, with particular emphasis on functional description of activities that can be performed by specific personnel, and the training and supervision required to insure quality service delivery. This recommendation is related to the President's Commission on Mental Health report recommendation on the integration of paraprofessionals into the mental health system.

e) The recruitment of promising minority and rural/based paraprofessionals and volunteers into professional levels of training programs. The Task Force on Personnel of the President's Commission on Mental Health recommends the acceptance of competency assessment procedures and transfer of credits on a wider basis than is currently being done in order to promote this recruitment.

f) The development of legislation to provide 1) reimbursement of third-party insurance payments for services provided by paraprofessionals, and 2) financial support for effective components of indigenous community support systems.

g) The development and funding of programs to educate the public about the availability and purposes of nonprofessional care-giving groups.

CONCLUSIONS

I have tried to make a case for the importance of utilizing nonprofessional community caregivers. These caregivers represent a valuable natural resource which, if utilized appropriately, will provide an important adjunct to the mental health service delivery system. However, this is not the only reason for promoting the use of nonprofessional caregivers. The manner in which we approach the issue of nonprofessional care will have a significant impact on the broader issue of developing a truly comprehensive mental health system. If we are able to effectively utilize nonprofessional personnel in groups, particularly with appropriate linkages provided by paraprofessionals, we will be taking a large step toward creating a comprehsive, community-based system of mental health services.

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